



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

NEW LICENSE APPLICATION
BOARD OF PSYCHOLOGY

Please read instructions before completing this form. If you have any questions, call HPLA Customer Service at **1-877-540-5827**, Monday through Friday, 8AM to 5PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

Section 1. REQUEST LICENSE TYPE/FEEES

Check the box next to the basis by which you are applying. *Do not select "EXAMINATION" if you have already passed the USMLE Step III Examination

PSY - Psychologist by Examination	\$247.00	Make check or money order payable to <u>Promissor</u>		
PSY - Psychologist by Re-Examination	\$91.00	Mail To: Department of Health Health Professional Liscencing Adminstration Board of Psychology 717 14th Street, NW, Suite 600 Washington, D.C. 20005		
PSY - Psychologist by Endorsement	\$247.00	Walk-in Service Monday through Friday, 9 to 4 EST 717 14th Street, NW, Suite 600 Washington, DC 20005		
PSY - Psychologist by Re-Endorsement	\$91.00			
Duplicate Licenses (limit 5)	X\$26.00=	\$.00	
Total Enclosed		\$.00	
		Check \$	HPLA ONLY Check #	Staff
		\$ _ _ _ .00		

Section 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you attended college or university, please complete Section 4 on page 2. You must also provide legal name change document for EACH time thatit has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court oders.

First Name	Last Name	MI	Suffix (Jr, Sr, etc.)
Social Security Number		Date Of Birth (mm/dd/yyyy)	
Place Of Birth		Male Female Gender Please Check the Correct Box	

Section 3. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included in this package **or** requested to be sent to the Board of Professional Psychology. Keep a photocopy of all supporting documents for your records.

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ONLY**

A.	Two recent passport-type photos of the applicant's face (approx. "2 X 2") with applicant's name printed on the back. Home snapshots or computer photographs are not acceptable.	<div><div>*</div>Yes No</div>	
B.	Character Reference List - On a separate sheet of paper list the names and addresses of three (3) responsible persons (other than relatives, instructors, or employers) who have known you for at least one year and can attest to your character.	<div><div>*</div>Yes No</div>	
C.	Official transcript (with seal) from the applicant's college or university. May be sent directly from the school, but is preferred that it accompany the application in a sealed envelope.	<div><div>*</div>Yes No</div>	
D.	Passing national exam at recommended score of 500 for the Examination of Professional Practice in Psychology (EPPP) examination, sponsored by the American Association of State and Provincial Psychology Boards (ASPPB).	<div><div>*</div>Yes No</div>	
E.	If you are or have ever been licensed in another state/jurisdiction: Verification of State Licensure from EACH state/jurisdiction.	<div><div>*</div>Yes No</div>	
F.	If licensed in other jurisdictions: Statement of more than two years of full-time practice or PS Form 02.	<div><div>*</div>Yes No</div>	
G.	A completed PS Form 03 and PS Form 04 (see instructions if applicable to your application).	<div><div>*</div>Yes No</div>	
H.	Copies of legal documents supporting all name changes.	<div><div>*</div>Yes No</div>	
I.	A completed and signed Clean Hands Form.	<div><div>*</div>Yes No</div>	

Section 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Changed to current name by: Marriage Divorce Court Order Spouse Death Certificate

First Name MI Last Name Suffix (Jr, Sr, etc.)

Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

Apartment Suite Floor PO Box
Number

Home Street Address 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

Home Street Address 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

City

State Zip Code + 4

Home Phone Number Home Fax Number Email Address

Section 5B. BUSINESS ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable. ZIP code should correspond to the PO Box number.

Company Name
Apartment Suite Floor PO Box
Number

Home Street Address 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

Home Street Address 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

City

State Zip Code + 4

Phone Fax Email

Section 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

Home Business

Section 6A. PROFESSIONAL SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical/professional schools. List in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certification

Section 6B. POSTGRADUATE EXPERIENCE

List all experience since graduation from medical/professional school, in reverse chronological order, beginning with the most recent. For "Type of Position," use the letter from the key below

Organization/Institution	Location	Start Date	End Date	Type of Position (Use Key Below*)	Full Time	Part Time

* TYPE OF POSITION KEY

A. Employment

B. Private Practice

C. Instructor

D. Clinical Rotations

E. Other (specify on separate sheet of paper)

Section 6C. PROFESSIONAL LICENSES IN OTHER STATES/JURISDICTIONS		
List all states and jurisdictions in which you have ever held a similar professional license. You must request and provide verification of licensure for all of these licenses, past and/or present.		
Jurisdiction	Date License Was First Obtained	License Number

Section 7. QUESTIONS		Applicants MUST answer all of the following questions		HPLA ONLY
Please answer all of the following questions by placing an 'X' in the appropriate boxes. If you answer 'Yes' to any of questions B through L below, you must provide full information and complete details on a separate sheet of paper and attach with this application form.				
A.	I certify that I am in compliance with the "Clean Hands Before Receiving a License or Permit Act of 1996" (DC Law 11-118, DC Code §47-2861 et seq.) and I do not owe any outstanding debt over \$100 to the District government as a result of any fine, fee, penalty, interest, or past due taxes as stipulated in that law.	Yes No *		
B.	Have you ever been arrested, indicted or convicted of a crime (other than minor traffic violations) not previously reported to the Board?	Yes No *		
C.	Are you now or have you ever been licensed in DC or any other state/jurisdiction? (If "Yes," be sure to complete section 6C of this form.)	Yes No *		
D.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	Yes No *		
E.	Have you ever voluntarily surrendered a license or registration certificate after formal charges have been filed against you or while under investigation?	Yes No *		
F.	Has any authority taken adverse action against your license or privileges or informed you of any pending charges not previously reported to this board?	Yes No *		
G.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	Yes No *		
H.	Have you ever been terminated from or resigned from a clinical or professional training program?	Yes No *		
I.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	Yes No *		
J.	Has the use of drugs and/ or alcohol resulted in an impairment of your ability to practice your profession?	Yes No *		
K.	Have you withdrawn an application (in DC or any other state/ jurisdiction) to practice your profession, or has any authority or peer review board taken adverse action against your license or privileges, or are you currently under investigation by any authority or peer review board for any violation of state, federal, or local law, or has any authority or peer review board informed you of any pending charges not previously reported to this Board?	Yes No *		
L.	Have you ever been terminated or asked to resign from employment since obtaining your (professional) license?	Yes No *		

Section 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LISENCEE SIGNATURE

NAME (please print)

DATE

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ONLY**

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.